REGISTERED MASSAGE THERAPIST

Massage Therapy Health History Form

Paige Cormier, RMT

The information requested below will assist me in treating you safely and effectively. Please note that all information provided below will be kept confidentially unless allowed or requested by law (your written permission will be required). Any questions regarding your visit, please feel free to ask!

Name: _____ Phone: _____ Date: _____
Address: _____ City: _____ Occupation: _____
Primary Care Physician: _____ Date of Birth: _____
Email: _____
What brings you in for a massage? _____
Have you had a massage before? _____
Overall, how is your general health? _____

*** Would you like to stay up-to-date regarding Special Offers, Promotions and Facts about Massage Therapy with Paige Cormier, RMT through Email? (You can opt-out at any time.) YES NO

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- o High Blood Pressure
- o Low Blood Pressure
- o Chronic Congestion
- o Heart Failure
- o Heart Attack
- o Varicose Veins
- o Stroke
- o Pacemaker
- o Poor Circulation
- o Heart Disease

Respiratory

- o Chronic Cough
- o Shortness of Breath
- o Bronchitis
- o Asthma
- o Emphysema
- o Problems Breathing

Women

- o Menstrual Problems
- o Gynecological Condition
  Which? _____
- o Pregnant
  Due? _____

Infections

- o Hepatitis: _____
- o Herpes
- o Skin Conditions
- o TB
- o HIV/AIDS

Previous Injuries/ Surgeries

Nature: _____
_____
Date: _____

Other Conditions

- o Liver
- o Gall Bladder
- o Kidney/ Bladder
- o Diabetes: _____
- o Insomnia
- o Cancer: _____
- o Loss of Sensation: _____
- o Arthritis: _____
- o Internal Pins/ Artificial Joints: _____

Head/ Neck

- o Headaches
- o Migraines
- o Vision Problems
- o Ear Aches
- o Vertigo/ Dizziness
- o Jaw Problems

Medications: _____
_____

Informed Consent

I understand that the purpose of massage therapy is to restore and maintain the integrity of the musculo-skeletal system. I understand that massage therapy is a hands-on health care discipline that will require the therapist to place his/her hands on those areas of the body that are involved in the cause of my symptoms. I am aware that my Therapist is a Registered Health Care Professional and has the right to discontinue the treatment at their discretion.

I understand that I have complete control of my own treatment and the right to change/alter, or discontinue the treatment at any time should I feel uncomfortable.

I understand that massage therapists do not diagnose illnesses, disease, or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary healthcare provider for that service.

I further understand that in the practice of massage therapy there is potential for mild side effects, including but not limited to, muscle soreness/point tenderness in areas worked (lasting up to 24-48 hours), mild bruising, headache, and possibly feeling lightheaded. Following the treatment feelings of fatigue are common. Cold packs on achy areas (10min on, 10min off) will help minimize any discomfort. Please feel free to call or email me at any time if you have any questions or concerns.

Fee is due at the time of treatment; cash, interac, visa, mastercard are accepted.
Without 24 hours' notice you will be billed for your missed appointment.

I, _____ have read and acknowledge all the above information and give my consent for massage treatment/ assessment.
(please print name)

Signature: _____ Date: _____

CMTO College of Massage Therapists of Ontario

Registered Massage Therapists' Association of Ontario